BEHAVIORAL HEALTH APPLICATION FOR SERVICES

San Luis Obispo Behavioral Health Department	☐ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805)-781- 4275 FAX (805) 781-1227	☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177

REFERRAL Who referred you? (check as many as apply)				
	☐Self ☐School ☐Employer ☐Family ☐Friends	☐ DUI ☐Jail ☐Medical/Physician ☐Medical Hospital ☐Child Welfare Services ☐Social Services	☐Court ☐Probation ☐Parole ☐Prop 36 Court ☐Adult Felony Drug Ct. ☐Post Release Comm. AB109	☐Mobile Crisis ☐Private Mental Health Practice ☐County Mental Health ☐Other Psychiatric Hospital ☐Vocational Rehab ☐SAFE
	☐OTHER specify:		☐OTHER specify:	☐OTHER specify:

Applicant Name (First, Middle, last, Jr. Sr., I or II)			
Applicant First Name as it appears on Birth Certificate			
Gender ☐ Female ☐Male ☐Transgender	Date of Birth	Date of Birth is ☐Actual ☐Estimated	Age
Applicant Street Address		City / State / Zip	
Mailing Address (if different than above)		City / State / Zip	
Home/Message Phone	Cell Phone	☐ OK to leave message?	Email Address
Driver's License Number	Driver's License State	Social Security Number	Reason no SSN given
BIRTHPLACE ☐SLO County	Other CA COUNTY- Specify	Other STATE Specify	Other COUNTRY Specify

MARITAL STATUS	Applicants MOTHER'S FIRST Name?	☐ Never Married ☐Married ☐Widowed ☐Divorced ☐Separated ☐ Domestic Partner

RACE ETHNICITY	Are you of Hispanic or Latin origin? ☐ Yes ☐ No					
		☐White	☐Other Hispanic	☐Laotian	☐Guamanian	☐Other Race Specify:
		☐Black	☐Hawaiian	☐Cambodian	☐Alaskan Native	
		☐Native American	☐Japanese	☐Korean	☐Samoan	
		☐Mexican/American	☐Chinese	☐Other Asian	☐Asian Indian	
		☐Latin American	☐Filipino	☐Vietnamese	☐Mixed Race	

LANGUAGE	PRIMARY LANGUAGE ☐ English ☐Spanish ☐American Sign Language ☐ Other (Specify)	☐Services needed in language other than English
	PREFERRED LANGUAGE ☐ English ☐Spanish ☐American Sign Language ☐ Other (Specify)	

WORK	☐Employed full-time (35 hrs or more per wk) ☐Unemployed (looking for work) ☐Not in labor force (not looking for work)
	☐Part time (less than 35 hrs per wk) ☐Unemployed (not looking for work) Not working because (reason)? ➡

LIVING ARRANGEMENTS				
	☐House/Apt/Mobile Home	☐Homeless in transition	☐Drug Residential Rehab	☐Correctional Facility Adult
	☐SRO Hotel, Motel/Rooming House	☐Homeless no County residence	☐Group Qtrs. dormitory, barracks , camp	☐Sober Living Environment
	☐Friend/Other	☐Group Home	☐Foster Home (Child/Yth)	☐Other

APPLICANTS FAMILY	Is applicant PREGNANT? ☐Yes ☐No	DUE DATE:	Number of Applicants Children 0-5 Years	Number of Applicants Children 6-17 Years
	Has applicant had or currently has an open Child Welfare Services case? ☐Yes ☐No		Number of children under 17 applicant cares for 50% of the time	
	Number of dependent adults applicant cares for 50% of the time			

EDUCATION	Highest Grade Completed	Vocational Program ☐Yes ☐No	Current School Name
	Specify Degree	Specify Vocational Program	School District of Residence

DISABILITY	☐1 Hearing ☐2 Visual ☐3 Mobility ☐4 Speech ☐6 Health ☐7 Developmentally Disabled ☐8 Other(not drug or alcohol) ☐12 Mental

MILITARY	Are you a Veteran ☐Yes ☐No ☐Decline to Answer	Do you have a military connected disability ☐Yes ☐No
	Do you have VA Benefits: ☐Yes ☐No	If yes, VA Claim Number

Other Names Used	First	Middle	Last

EMERGENCY CONTACT	Name	Phone	Work Phone
	Address		Relationship to Applicant

LEGAL INFO	Probation Contact Name & Phone #	Court Case #	Social Worker's Name & Phone #
	Parole Contact Name & Phone #	CDC Number #	Other/Conservatorship/JuvCourt300/601/602

FINANCIAL	What is your monthly family income?	How many people live on your income including you?
	MediCal? ☐Yes ☐No	MediCal/CIN Number (eg. 123456789A)
	Medicare Number	Private Insurance ☐Yes ☐No

CLIENT NAME:	DATE	CLIENT NUMBER

SIGNATURE PAGE San Luis Obispo Behavioral Health Department	☐ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX(805) 781-1227	☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177

TREATMENT AUTHORIZATION

TREATMENT AUTHORIZATION: I, the undersigned, am requesting mental health services and/or drug and alcohol services and give my consent to the staff of the San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to administer such treatment as is considered therapeutically necessary and/or desirable. All treatment procedures, including observed urinalysis for drugs of abuse, patching, and breathalyzer, are to be discussed with me and I am free to decline or withdraw from treatment at any time. I expect to receive quality, professional care and understand that there is no guarantee that desired results will be obtained. I understand that San Luis Obispo County Mental Health and/or Drug and Alcohol Services will maintain a medical record of my contacts for services as required by law. This is a shared electronic health record between Mental Health and Drug and Alcohol Services. The confidentiality of these records is protected by law and no information which might identify me will be released without my specific written consent. Exceptions to this confidentiality are: Medical emergencies, the requirements for billing, a judge's order to release information to a court, unreported abuses of a child, dependent adult or elder, or in the event that I am of danger to myself or others.

Client Signature _____ Date_____

Parent, Guardian or LPS Conservator Signature_____ Date_____

Legal Consent	
Responsible Person	
Address, City, State, Zip	Phone

INSURANCE AUTHORIZATION

I hereby authorize San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to receive payment of medical benefits for any and all health insurance plans for which I am covered, including Medi-Cal, MEDICARE and private health insurance. I further authorize the San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to disclose portions of any record generated or maintained by Mental Health Services and/or Drug and Alcohol Services regarding me, including all health information pertaining to my medical history, mental or physical condition and treatment received, and information recorded in the diagnosis and treatment of my mental health and/or drug and alcohol related conditions, to any person or corporation which is or may be liable for, all or any portion of Mental Health Services and/or Drug and Alcohol's charges, including, but not limited to insurance companies, health care service plan, or workers' compensation carriers and government reimbursement entities. The purpose of the disclosure authorized by this form is for Mental Health Services and/or Drug and Alcohol Services to determine liability for payment and to obtain reimbursement for its own or ancillary services. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year (1 year) from the date the case closes. I understand that I might be denied services if the County can, under federal or state law, condition treatment on the provision of an authorization, such as to obtain information in connection with a health plan's eligibility or enrollment determinations. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of under this authorization. I have been provided a copy of this form.

Client/Responsible Party Signature : _____ Date_____

RECEIPT OF CLIENT HANDBOOK

I have received a copy of the following: (Initial each line as it applies to each client)

1.____ Privacy Practices - I hereby acknowledge that I received a copy of County of San Luis Obispo Health Agency Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the lobby area, and that I will be offered a copy of any amended Notice of Privacy Practices at my appointment.
2.____ Client's Rights and Grievance Procedures. This is also posted in the lobby area.
3.____ HIV/AIDS, Hepatitis C, and TB Information sheet. Phone numbers included for testing and referrals.
4.____ Information on Drug Testing including: Drug testing guidelines, medications/substances that may test positive on your drug screen, and over-the-counter medications okay to take while drug testing.
5.____ Follow-Up Consent - I agree to comply with the San Luis Obispo County follow-up procedure. I understand that this entails responding to a questionnaire regarding my status at 90 and 180 days after discharge from the program. I further understand that this information will be strictly confidential, and that I may be offered a follow-up appointment based on the information I give.
6.____ Advance Directive
7.____ List of Community Service Providers has been given to me.
8.____ Beneficiary Medi-Cal Handbook
9.____ *I have read, understand, consent, acknowledge and agree to abide by the terms and conditions in the Client Handbook.*

Client Signature:_____ Date_____

Parent, Guardian or LPS Conservator Signature_____ Date_____

Signature of Staff Person Witnessing:_____ Date_____

If not signed by the client, please indicate relationship:

☐Parent or guardian of minor client ☐Guardian or conservator of an incompetent client ☐Beneficiary or personal representative of deceased client

CLIENT NAME	CLIENT NUMBER

Welcome!

Drug and Alcohol Services

Client Handbook

Drug and Alcohol Services Client Handbook

Welcome to Drug and Alcohol Services! Our primary goal is to promote safe, healthy, responsible, and informed choices concerning alcohol, and other drugs. We have many programs that range from prevention of drug and alcohol use to treatment of chemical dependency. We hope to provide a program that fits your unique and specific needs.

You will have the opportunity to meet with a specialist (counselor) to discuss your goals, needs, and requirements. You are provided this Client Handbook that will also answer some of your questions.

All programs at Drug and Alcohol Services are ***confidential.*** Confidentiality means the information you share is protected by law and will only be shared with the parties you have requested. *It is absolutely imperative and a legal necessity that* ***all*** *client names and information are kept private.*

San Luis Obispo Clinic **2180 Johnson Avenue** **SLO, CA 93401** **805-781-4275** Drug Testing Color Code SLO: 805-788-2902 Testing Hours 3:00-6:00 PM	**Grover Beach Clinic** **1523 Longbranch Avenue** **GB, CA 93433** **805-473-7080** Drug Testing Color Code GB: 805-788-2902 Testing Hours 3:00-6:00 PM	**Atascadero Clinic** **3556 El Camino Real,** **AT, CA 93422** **805-461-6080** Drug Testing Color Code Atas: 805-788-2902 Testing Hours 3:00-6:00 PM

My primary Counselor is:_____Phone_____.

My Color for Testing is: _____ at clinic: SLO GB ATAS

My first Appointment is:_____.

Drug and Alcohol Free Zone:

San Luis Obispo County Drug and Alcohol Services is a ***Drug and Alcohol Free Zone***.

- Alcohol or other drug use is not permitted. This includes all tobacco products (cigarettes, cigars or chewing tobacco).
- Smoking or chewing tobacco is not permitted in the immediate area of the building, but is permitted, *by adults*, in private vehicles and on public sidewalks.



No weapons policy: San Luis Obispo County Drug and Alcohol Services has a no weapons policy. This includes knives, guns, or other weapons (except for law enforcement officers or security guards acting in the line of duty) at the program site.

Client's Rights & Grievance Procedure

Services are offered without discrimination by race, religion, color, national origin, ancestry, physical or mental disabilities, medical condition, marital status, age, sex, sexual preference or ability to pay. All treatment procedures will be discussed with clients and clients are free to withdraw from services at any time. Federal Law (CFR42) protects confidentiality of services at this facility and no information that will identify a client will be released without client's specific written consent. *Exceptions to this confidentiality are: medical emergencies, a judge's order to release the information, suspected abuse of a child, dependent adult or elder, or in the event that a client is of danger to self or someone else.*

Each Medi-Cal beneficiary has the right to a fair hearing related to denial, termination or reduction of Drug Medi-Cal services. Procedures outlined in Title 22, California Code of Regulations, Sections 50951 and 51014.1; Welfare and Institutions Code, Sections 10951 through 10965; and the Department of Social Services (DSS) Manual of Policy and Procedures, this organization, the Utilization Review Committee, and the beneficiary will follow Chapter 22.

Access to treatment files is in accordance with Executive Order #B-22/76. The drug treatment program will comply with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and California Government Code Section 11135,et seq.

Client Rights: During participation in the program, the client has the right to the following:

1. Be provided with a clean environment free from health and safety hazards.
2. Be free from humiliation, intimidation, ridicule, coercion, threats, verbal, emotional, physical abuse and/or inappropriate sexual behavior from program staff or other program participants.
3. Have program rules, requirements, fees and payment schedules explained.
4. File a written grievance with the Program Supervisor pursuant to the following procedures.

Grievance Procedures: the Specialist assigned to your case can handle most questions, comments or complaints**. However, in the case where satisfactory resolution is not obtained:**

1. **Written Grievance**: A client has the right to appeal any program decision by expressing his/her concerns in writing within five (5) working days of that decision. This written request for consideration must contain a statement of the program decision being appealed, the name of the participant, the date of the decision, and the participant's basis of appeal.
2. **Submission of Grievance to the Program Supervisor:** The client must submit the above-described written appeal within five (5) days of the decision in question to the Program Supervisor. The Program Supervisor, or his/her designee if the Program Supervisor is on leave during this period, shall respond in writing to the client within fifteen (15) working days of receipt of complaint.
3. **Submission of Grievance to the Division Manager:** If the client is not satisfied with the response received from the Program Supervisor, the participant may send the written grievance to the Division Manager or within five (5) working days of the receipt of the response from the Program Supervisor. The Division Manager or his/her designee in turn must respond in writing to the client within fifteen (15) working days.

Address: Division Manager at 2180 Johnson Avenue, San Luis Obispo, CA 93401

Grievances regarding any action, complaints or appeals may also be addressed to the State Department of Alcohol and Drug Programs, Residential and Outpatient Programs Compliance Branch, 1700 K Street, Second Floor, Sacramento, CA 95814. Phone: (916) 322-2911 or call 1-800-743-8525 or T.D. 1-800-952-8349. Program rules and regulations are in compliance with State of California Alcohol and other Drug Programs Certification Standards.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective October 1, 2009 (revising and replacing all previous Notices).

Your health information and records are personal and private. We take our responsibility to protect your health information seriously. This Notice tells you how we may use and share your health information, what your rights are concerning your health information, and who to call if you have questions. The County is legally obligated to make sure your medical information is protected to the full extent of the law, to give you this Notice of our legal duties and privacy practices with respect to medical information about you, and to follow the terms of the Notice that is currently in effect.

HOW WE MAY USE OR SHARE YOUR HEALTH INFORMATION:

The following categories describe different ways that we may use and disclose medical information. **Some information such as certain drug and alcohol information, HIV information, and mental health information may be subject to special additional restrictions related to its use and disclosure.** The County abides by all applicable state and federal laws related to the protection of this information. Generally, the County may use and disclose medical information about you in the following circumstances:

Disclosure at Your Request: when requested by you or by someone who has a legal right to act for you. This disclosure may require a written authorization.

For Treatment: to help ensure you receive the care you need. We will only use your health information in ways that are appropriate for your health care needs.

For Payment: as needed to bill, collect, and/or pay for your health care and as the law requires.

For Health Care Operations: for certain health care operations to assure that all of our clients receive quality care and customer service (for example, to contact you about new or changed benefits).

To Avert a Serious Threat to Health or Safety: when necessary to address a serious threat to the health and safety of you, another, or the public. Any disclosure would be only to help prevent or reduce the threat.

For Public Health and Research: for public health purposes, including, but not limited to the following: to prevent or control disease, injury, or disability; to report vital events such as births and deaths; to report abuse or neglect of children, elders, and dependent adults; to report adverse events or surveillance related to food, medications, or products; to notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; to report to an employer findings concerning a work-related illness or injury or workplace-related medical surveillance; and for research studies as authorized by law.

For Health Oversight Activities: to governmental, licensing, auditing, and accrediting agencies. For example, a federal agency evaluating the County's billing of Medi-Cal or the County's own investigation into Medi-Cal fraud or abuse.

(Continued on back)

For Law Enforcement: in certain circumstances, to a law enforcement official in response to a warrant or similar process, to identify or locate a suspect, and to provide information about the victim of a crime, or about a death which we believe may be a result of criminal conduct, or about criminal conduct at the County.

For Legal Proceedings and Lawsuits: to courts, attorneys, and court employees in the course of conservatorship and certain other proceedings. The County may also disclose medical information in response to a court or administrative order, a subpoena, warrant, summons, or other lawful process.

As Otherwise Required by Law: ***when required to do so by federal, state, or local law or regulation (for example, to Worker's Compensation or similar programs as authorized by law).***

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the right to:

- Inspect and copy your personal medical information.
- Request an amendment to your medical information if you believe that it is incorrect or incomplete. If the County denies your request, a statement of your position may be added to your record.
- Receive a list of the disclosures we have made of your medical information. This accounting of disclosures must be requested in writing to the Privacy Official. Your request must state a time period that may not be longer than the six previous years.
- Ask the County to communicate with you by a particular method or location.
- Ask the County to limit how your personal medical information is used. Please note that the County may not be able to agree to your request.
- Get a copy of this Notice at any time.

CHANGES TO THIS NOTICE

The County reserves the right to change its privacy practices and this Notice and to make the new Notice effective for medical information we already have about you. The new notice will contain the effective date on the first page and be posted in prominent Health Agency locations.

QUESTIONS OR COMPLAINTS

If you have questions or would like more information about this Notice, please call:

Behavioral Health (Mental Health and Drug & Alcohol Services) . . . .(805) 781-4738
All other Health Agency queries . . . . . (805) 781-5500

Written questions may be addressed to: **Privacy Official, 2180 Johnson Ave., San Luis Obispo, CA 93401**

If you believe your privacy rights have been violated, you may file a complaint with the County or with the Secretary of the Department of Health and Human Services. To file a written complaint with the County, contact the **Privacy Official** at the above address. *You will not be penalized for filing a complaint*.

OTHER USES OF YOUR MEDICAL INFORMATION

Any uses not covered by this Notice or applicable laws will be made only with your written permission. You may revoke that permission in writing at any time, which will apply to future use or disclosure. The County would be unable to take back any disclosures already made with your permission and would still be required to maintain our records of the care provided to you as required by law.

HIV, Hep C and TB Information & Referrals

What is AIDS?

Acquired Immune Deficiency Syndrome is caused by a virus called HIV (Human Immunodeficiency Virus). The virus can destroy the body's ability to fight off infection. The person may then get sick and not be able to get well again.

How do you get HIV?

Participating in high risk behaviors such as: unprotected sex—vaginal/anal/oral, needle sharing—tattoo needles included; having sex with someone who does the above; exchanging sex for money or drugs. Having a sexually transmitted disease may put you at increased risk for contracting HIV. The virus can pass from mother to baby during pregnancy.

How can you find out if you have HIV?

There is a special test called the HIV antibody test. If the test result is "Positive," it shows that you are infected with HIV. It does not tell you if you have AIDS. You need to see a doctor to find that out. If the test is "Negative," it means you either have not been infected or not enough time has passed to show the infection (6 months).

What is Hepatitis C?

Hepatitis C is a liver disease cause by the Hepatitis C virus, which is found in the blood of persons who have this disease. Hepatitis C is serious for some persons, but not for others. Most people who get Hepatitis C carry the virus for the rest of their lives.

How Do You Get Hepatitis C?

Hepatitis C is spread by contact with an infected person's blood. Examples of this include: sharing drug injection equipment (including things other than the syringe); having received a blood transfusion prior to 1992; having multiple sexual partners; and possibly sharing razors, toothbrushes, tattoo and piercing equipment.

How Do Know if You Have Hepatitis C?

Many persons with long-term Hepatitis C have no symptoms and feel well. For some persons, the most common symptom is extreme tiredness. The only way to know if you've been infected is to have a blood test that looks specifically for the Hepatitis C virus.

What is TB?

"TB" is short for a disease called *Tuberculosis*. The TB germ is spread from person to person through the air. If someone coughs, sneezes, laughs, or shouts the germs are put into the air and people nearby may breathe the TB germs into their lungs. A person can become infected by the TB germ if breathed in.

Who gets TB?

Anyone can get TB, but substance users and people who have AIDS are at higher risk. Living in an environment with a lot of other people or being homeless also increases the chances of being exposed and/or infected by the TB Germ.

How do you know if you have TB?

A skin test is the only way to tell if you have been exposed to TB. A chest X-ray can tell if you have the infection or if there is damage to your lungs from TB disease. Having the disease can cause symptoms such as weakness, weight and/or appetite loss, high fever, or sweating a lot at night. If you have ever had any of these symptoms please tell your doctor.

Resources

There are options in SLO County for HIV, Hep C, and TB testing. If you have a primary physician, you may want to discuss options with them. Below are a few of the community resources:

- Public Health Department for HIV testing, TB testing, family planning
    - San Luis Obispo 805-781-4896 Paso Robles 805-237-3050
- EOC Clinical Services (testing, pregnancy, contraception, & other) 805-544-2478
- Community Health Centers (most medical needs)

South County: 805-481-7220 **San Luis**: 805-269-1500 **North County**: 805-792-1400

What Over- the-Counter medications are <u>OKAY</u> to take

For a Cold/Allergies

Afrin Nasal Spray	Genahist	Neo-Synephrine Nasal Spray	Sucrets
Benadryl	Guaifenesin	Organidin	Tavist (NOT D)
Chloraceptic	Hall's Metho-Lyptus	Propylene Glycol/Polythylene Spray	Triaminic
Chlortrimeton tablets	Humibid Med quell Squares	Rhinaris	Uni-Hist
Claritin (NOT Claritin D)	Mucinex	Robitussin	Vicks Cough Disks
Diphenhydramine	Naldecon Senior DX	Salinex	Vicks Cough Silencers Vicks
Delsym Liquid	Naldecon Senior EX	Spec-T	Lozenges
Dextromethorphan	Nasal Saline		Teldrin Tablets
Fenesin			Zyrtec

For Pain and Sleep

Acetaminophen	Ascriptin	Ibuprofen	Non-aspirin pain reliever Orudis
Actron	Aspirin	Medipren	Pamprin
Advil	Bufferin	Melatonin	Premsyn
Alka Seltzer	Datril	Midol	Sominex
Aleve	Ecotrin	Motrin	Tylenol
Anacin	Empirin	Naproxen	Valerian Root
Anaprox	Excedrin	Naprelan	

For Gastrointestinal Problems

Alophen Tablets	Docusate/Ducolax	Loperamine	Prilosec
Altemagel	Dramimine	Lopex	Riopan
Amphogel	Fleets Enema Dulcolax	Maalox	Rolaids
Benefiber	Emetrol	Metamucil	Senna
Camalox	Ex-Lax	Milk of Magnesia	Senokot
Citromag	Gas-X	Mitrolan	Surfak
Correctol Tablets	Gaviscon	Mylanta	Emetrol
Colace	Gelusil	Mylicon	Mylicon
Diasorb	Fiber-Con	Modane	Diar-Aid Tablets Tums
Dialose Plus	Fibermed	Neoloid	Omeprazole
Digel	Fleets Enema	Metamucil Pepcil	Pepto Bismol
Donnagel	Imodium	Pepto Bismal	Rheban
Doxidan	Kaopectate	Peri-Colace	Tagemet
		Perdiem Granules	Zegerid

For Toothache/Cold Sore/Topical

Ambesol	Campho-Phenique	Gynezol	Numzident
Amosan	Carmex	Femstat	Polaris Poultice
Aveeno	Cortaid	Hepecin-L	Sarna Lotion
Balmex	Desitin	Hydrocortisone	Salicyclic Acid
Bentoquam	Domeboro	Ivy block	Tanac
Benzodent	Duofilm	Monistat	Vagistat
Blistex	Gold Bond	Orajel	Zinc oxide
Boudreaux Butt Paste	Gly Oxide	Orasept	
Burows Soluntion	Gyne-Lotrimin	Pramoxine	

Herbal Supplements

There are many herbal supplements on the market, so if it is not listed here check with your counselor before you start using it.

Aloe	Echinacea	Ginko Biloba	Saw Palmetto
Andrographis	Garlic	Ginseng	St. John's Wort
		Kava	Valerian

Nicotine Replacements are all OKAY to take (gum, patch, oral, etc)

IMPORTANT: Before you take any mind or mood altering medications, discuss with your primary counselor (except in emergency situations). Please bring in a copy of your current prescription(s) to keep on file.

What's not okay	Do not use
Use of any medication that has not been prescribed to you	Any medication containing alcohol;Tinctures
Exceeding the recommended dosages of either prescribed or over-the-counter medications	Any medication/supplement containing ephedrine
Use of any illicit drug	Any tea or herbal supplement containing mah juang
	Over-the-counter diet pills

If you are unsure about a medication, consult your primary counselor before taking it!

Remember, When in doubt…..don't take it!

Drug and Alcohol Services
San Luis Obispo County

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:
CRIMINAL JUSTICE REFERRAL

Name of Client:_____DOB_____

I hereby consent to communication between San Luis Obispo County Drug and Alcohol Services and:

☐ **Court**	☐ Parole Department	☐ Probation
☐ **DMV**	☐ **Dept Health Care Svcs**	☐ Attorney and District Attorney
☐ Residential facilities	☐ Alternative Treatment Providers	☐ Jail staff

Out of County Court/Probation (specify) _____

Other referring Agency (specify) _____

The purpose of and need for the disclosure is to inform the applicable criminal justice/treatment agency (ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis/breathalyzer results, payment record, and treatment plan.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation or parole, or other proceeding under which I was mandated into treatment.

It is okay to leave messages on my machine or service ☐**Yes** ☐**No Your Phone #**_____

☐ Family members listed below for phone messages, payment information and scheduling of appointments.

Name	Relationship to Client	Phone #

I understand that my alcohol and/or treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties. I understand that generally San Luis Obispo County Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Special terms regarding revocability of Criminal Justice Program releases

Although HIPAA requires that consents be revocable and does not have an exception when a patient is mandated into treatment through the criminal justice system, 42 C.F.R. Part 2 sets forth some special rules when a patient's participation in a treatment program is an official condition of probation or parole, sentence, dismissal of charges, release from imprisonment, or other disposition of any criminal proceeding. While a consent form (or court order) is still required before any disclosure can be made about a criminal justice system ("CJS") referral, the rules concerning duration and revocability of the consent are different.

Under the special rules of 42 C.F.R. Part 2, consent can be made irrevocable until a certain specified date or condition occurs, and the duration of the consent can be linked to the final disposition of the criminal proceeding. 42 C.F.R. § 2.35. This allows programs to provide information even after the client leaves treatment. If the client does not comply with treatment, the program can report the problem to the judge or prosecuting attorney or testify in a probation revocation hearing because there has been no final disposition of the criminal matter. A CJS consent allows programs to use the expiration condition provided in 42 C.F.R. Part 2: "when there is a substantial change in the patient's criminal justice system status." A substantial change in status occurs whenever the patient moves from one phase of the criminal justice system to the next. For example, if a client were on parole or probation, there would be a change in criminal justice system status when the parole or probation ends, either by successful completion or revocation. Thus the program could provide periodic reports to the parole or probation officer monitoring the client, and could even testify at a parole or probation revocation hearing, since no change in criminal justice status would occur until after the hearing.

Dated:_____ _____
Signature of Client

_____
Signature of parent, guardian or authorized representative
(if required)

CLIENT NAME:_____ **CLIENT NUMBER:**_____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
DEBT COLLECTION

Name of client:_____DOB:_____

I authorize San Luis Obispo County Drug and Alcohol Services to disclose to:
The San Luis Obispo County Probation Department or other collection agency

And I authorize the Probation Department or other collection agency to redisclose to:
The courts, attorneys, the State Franchise Tax Board and any other person or entity as necessary to collect or facilitate collection of any fees owed for services provided to me by the San Luis Obispo County Department of Drug and Alcohol Services and associated collection charges.

The following information: any information that will facilitate collection of fees owed

The purpose of the disclosure authorized in this is to:
Facilitate collection of fees owed and associated collection charges, which includes, without limitation, pursuing collection through the State Franchise Tax Board or a court of law.

☐ Family members listed below for phone messages, payment information, and collections status.

Name	Relationship to Client	Phone

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
Upon payment in full of all fees owed and associated collection charges.

I understand that generally San Luis Obispo County Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Revocability of Release

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. Part 2 you have the right to revoke any release of information that you have previously signed giving San Luis Obispo Drug and Alcohol Services permission to release information to another agency, business, person, or organization. However, both HIPAA and 42 C.F.R. Part 2 provide that if a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information it has already disclosed. 45 C.F.R. § 164.508(b)(5); 42 C.F.R. § 2.31(a)(8).

Dated:_____

_____
Signature of Client

_____
Signature of parent, guardian or authorized representative where required

CLIENT NAME:_____ **CLIENT NUMBER:**_____

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES

A Public Service Agency

Participant's Certification of DUI Program Enrollment or Completion

(Instructions for completing this form are on the reverse side.)

PROGRAM PROVIDER NAME:	PROVIDER'S ADP LICENSE NUMBER
SAN LUIS OBISPO COUNTY DRUG & ALCOHOL SERVICES	0-001-01-120

PARTICIPANT NAME: (LAST FIRST MIDDLE)	DRIVER LICENSE NUMBER OR "X" NUMBER

PROGRAM TYPE

☐ Education Only (23140 CVC Conviction) ☐ First Offender Program ____ months

☐ Multiple Offender Program ____ 18 months ____ 30 months ____ 18 of 30 months (IID Restriction only)

ENROLLMENT DATE	DL 107 CERTIFICATE NUMBER	OR	COMPLETION DATE	DL 101 CERTIFICATE NUMBER

I certify under penalty of perjury under the laws of the State of California that I have enrolled in, or completed the program as indicated above.

DATE	PARTICIPANT'S SIGNATURE	TELEPHONE NUMBER
	✍	( )

DL 804 (REV. 1/2003)

Instructions for Completing the Participant's Certification of DUI Program Enrollment or Completion (DL-804)

This form is to be used under the following circumstances:

- When a program participant has completed all the required DUI Program components, but you are unable to immediately issue a Notice of Completion Certificate (DL 101) and capture the participant's signature on the (paper) completion certificate.
- When a program participant has completed all the required DUI program components and you are submitting an electronic Notice of Completion Certificate (DL 101) via an authorized Internet access link with the Department of Motor Vehicles (DMV).
- When a program participant has enrolled in a DUI program and you are submitting an electronic Proof of Enrollment Certificate (DL 107) via an authorized Internet access link with the DMV.

This form captures the participant's signature, which certifies under penalty of perjury that the participant has either enrolled in a DUI program, or completed the required DUI program. This signature would normally be on the DL 101 or DL 107, but in the above circumstances you may not be able to capture the participant's signature on the certificate.

Please, ensure that the information on this form is consistent with the information on the Proof of Enrollment Certificate (DL 107) or the Notice of Completion Certificate (DL 101) you submit for the identified participant.

You must retain this form in your office in a manner that will allow you to retrieve it by searching for the serial number of the corresponding Certificate (DL 107 or DL 101) and for the period required by Section 9866 of Title 9, California Code of Regulations.

On the printed Notice of Completion Certificate (DL 101) you submit without a participant's signature, type or print the words "Signed DL 804 in file" in the space provided for participant's signature.

Do not submit a DL 804 to DMV unless you are requested to do so.

DL 804 (REV. 1/2003)